Expediting the Disability Process for Patients Seeking Long Term Care

Prepared by

Jimmy Hampton

Regional Administrator

South Carolina Department of Health and Human Services

February 6, 2012

Table of contents

Expediting the Disability Process for Patients Seeking Long Term Care

One of the major problems identified by hospital discharge planners are the length of time some patients must remain in hospitals awaiting a disability determination for Medicaid. There are several points of view surrounding this issue. There are some that believe that a quick disability decision would allow the patient to receive rehabilitation services at an early stage of the illness or injury which could potentially improve the condition and lessen the need for continued long term care. Others believe that an immediate decision would allow the patient to be discharged more quickly from the hospital to a nursing home or community setting for in-home care, thereby creating a cost savings to the state's Medicaid program. Regardless of their point of view, all hospital discharge planners believe the disability process in South Carolina should be expedited for patients with certain medical conditions, injuries, and illnesses.

These points of view or beliefs are examined by first taking a close look at the current processes for patients applying for long term care disability Medicaid in South Carolina.

The current process requires all patients or their authorized representative to first file a Medicaid application with an eligibility worker of the South Carolina Department of Health and Human Services (DHHS), regardless of illness or condition. Once the application is filed, the eligibility

worker forwards a referral for disability over to the South Carolina Department of Vocational Rehabilitation's disability determination unit. Next, the eligibility worker determines the Medicaid program category of assistance based on the applicant's need and allegations in their application. Once the program category is determined, the eligibility worker conducts a non-financial and financial investigation based on the state's Medicaid policies and procedures. This investigation requires gathering personal and financial information from the applicant, authorized representative, or third party sources. When all non-financial and financial information is received and the applicant meets the program guidelines, the eligibility worker must wait for a favorable decision/allowance from South Carolina Department of Vocational Rehabilitation before the case can be approved for Medicaid. The average length of time patients must wait before approval for Medicaid is 90 to 120 days. In cases where there is an administrative delay in securing needed information from third party sources, this length of time can exceed 120 days.

South Carolina Department of Vocational Rehabilitation has dual roles. As this state's Disability Determination Services (DDS), they work in conjunction with the Social Security Administration to provide disability determinations as well as the state's Medicaid program. They also determine if a claimant is a candidate for vocational rehabilitation. If so, they make a referral to the appropriate department within the vocational rehabilitation agency.

The Social Security Administration administers two programs that provide benefits based on disabilities. They are the Social Security disability insurance program (Title II of the Social Security Act) and the Supplemental Security Income (SSI) program (Title XVI of the Act). Title II provides payments for disability benefits to individuals who are insured under the act by virtue

of their contributions to the Social Security trust fund through the Social Security tax on their earnings, as well as certain disabled dependents of insured individuals. Title XVI provides for Supplemental Security Income payments to individuals (including children under age 18) who are disabled and have limited resources. The Act and Social Security Administration (SSA) regulations prescribe rules for deciding if an individual is disabled. However, SSA criteria for deciding if someone is disabled are not necessarily the same as the criteria applied in other Government and private disability programs.

For individuals applying for disability under Title II and for adults applying under Title XVI, the definition of disability is the same. Under SSA, the law defines disability as the inability to engage in any substantial gainful activity (SGA) by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than twelve (12) months. Under Title XVI, a child under age eighteen (18) is considered disabled if he or she has a medically determinable physical or mental impairment or combination of impairments that cause marked and severe functional limitations, and that can be expected to cause death or that has lasted or can be expected to last for a continuous period of not less than (12) months.

Most disability claims are processed through a network of local Social Security field offices and state agencies such as S. C. Vocational Rehabilitation. With this process, the field offices usually obtain the applications for disability benefits in person, by telephone, by mail, or via online application process. This application and related paperwork ask for description of the applicant/claimant's impairment(s); names, addresses, and telephone numbers of treatment sources; and other information that relates to the alleged disability. The SSA field office is

responsible for verifying non-medical eligibility requirements, much like the Medicaid eligibility worker in the independent disability determination process. These SSA requirements may include verifying age, marital status, employment, citizenship/residency and Social Security coverage information, and additionally, for SSI eligibility, income, resources, and living arrangement information. Once the field office verifies the non-medical information, they send the case to Vocational Rehabilitation for evaluation of disability. South Carolina Department of Vocational Rehabilitation is responsible for developing medical evidence and rendering the initial determination on whether the claimant is or is not disabled or blind under the law. Once the case arrives at the Vocational Rehabilitation's Disability Determination Unit (DDS), it is assigned to a disability examiner.

The disability examiner attempts to gather medical evidence from the applicant/claimant's own medical sources first. Medical evidence is the cornerstone of disability determination under Title II, Title XVI, and for the state Medicaid program. In situations where medical evidence is not available or insufficient, the examiner will arrange for a consultative examination in order to obtain additional or needed information. After the medical evidence requested is received and developed, South Carolina Vocational Rehabilitation makes a disability determination. The entire process of gathering all of the necessary medical evidence for developing a claim can often take several months, depending on the impairment and it's severity. Another factor that may affect the length of time it takes to develop claims may be associated with the body of work this disability unit is responsible for producing. Handling all disability claims in South Carolina for Title II, Title XVI, and the state`s Medicaid program is a huge task for any agency/unit.

There are two silver linings in the Social Security Administration disability process which benefits those in urgent need. These two huge positives are found in their compassionate allowances initiative and Supplemental Security Income Presumptive Disability component. The Compassionate Allowances initiative identifies claims where the nature of the applicant's disease or condition clearly meets the statutory standard for disability. With the help of sophisticated new information technology, the agency can quickly identify potential Compassionate Allowances and then quickly make decisions. Social Security launched its compassionate allowance program in 2008 with a list of 50 conditions. As of today, that list has been increased to 113 conditions. Social Security communicates these updates through press releases and the Social Security Administration website.

Within the Supplemental Security Income (Title XVI) presumptive disability component, the Social Security Administration temporarily pays Supplemental Security Income (SSI) benefits while it gathers the evidence it needs to make a decision on a disability case. This procedure is called Presumptive Disability. Along with this temporary payment, individuals receive Medicaid through their states. Prior to issuing a presumptive disability decision, the Social Security Administration must have information or evidence that strongly suggest the individual will be deemed disabled. Presumptive disability only applies to Supplemental Security Income (SSI) cases and includes children. Presumptive disability only applies to initial cases. A case that has been denied at the initial level and now going through the appeal process will not be eligible for presumptive disability. Under a presumptive disability decision, a person can only receive benefits for up to six months. There are several medical conditions in which the Social Security Administration can perform presumptive disability. They are as follows: Amputation of the leg at the hip, total blindness, total deafness, confinement to bed due to a longstanding condition,

confinement to a wheelchair due to a longstanding condition, a stroke at least 3 months in the past resulting in inability to walk requiring the use of a wheelchair/cane/walker or severe inability to use one hand, cerebral palsy, muscular dystrophy, or muscular atrophy resulting in the inability to walk requiring the use of a wheelchair/cane/walker or a severe limitation on the use of one's hands, Down's Syndrome, severe mental deficiency in someone older than 7 years old resulting in the need for assistance with daily activities, baby less than 6 months old with a birth weight of less than 1200 grams, HIV with allegation of a resulting infection that meets SSA's requirements, hospice care for cancer, spinal injury greater than 2 weeks old resulting in an inability to walk requiring the use of a cane/wheelchair/walker, and severe prematurity- with weight below a certain level for the child's gestational age based on a chart contained in SSA's regulations.

The combination of the compassionate allowance initiative and presumptive disability within the Social Security administration process provides urgent care for those in need of medical assistance.

A look at other state's Medicaid program and presumptive eligibility processes provided some interesting insights. The states researched included Georgia, Colorado, Oregon, Kansas, Kentucky, Wisconsin, North Carolina, Indiana, and New Mexico. The purpose of this research was to determine if other states have implemented a policy or program to address the urgent need of patients seeking long term care and rehabilitation services. Except for states bordering South Carolina, others were randomly selected to include a cross section of the country. It was also important to see if programs already existed in other states that could potentially be adopted here in South Carolina. Whereas, nearly all states offers presumptive Medicaid in some form to

pregnant women, only two were found with a presumptive disability process. These two states with some type of presumptive disability process in place for their residents are Kansas and Wisconsin. The most interesting and beneficial presumptive disability process for patients seeking long term care was found in the state of Wisconsin.

In Wisconsin, individuals with an urgent need for medical services, and will likely be determined to be disabled by the Disability Determination Bureau (DDB), but have not yet been found disabled, may apply for Medicaid presumptive disability. If the individual is determined presumptively disabled, they will be able to receive Medicaid covered services, until a final disability determination is made. In some cases, the local agency or eligibility worker will be able to determine if the individual will be able to get presumptive disability. A presumptive disability determination is not the final decision. The individual's Medicaid disability applications must still be sent to the DDB for processing and final determination.

In Wisconsin, the individual must complete a two page application for presumptive disability. Under Wisconsin guidelines, a medical licensed professional must attest to the need for urgent care, either in a hospital, nursing home, or other long term care medical institution. Once this two page application is completed, it is sent over to the Disability Determination Bureau for a presumptive decision. This application also lists impairments much like the Social Security Administration uses in its SSI presumptive disability process. In fact, many of the impairments/conditions listed for Wisconsin are exactly the same as those under the SSI presumptive disability process. For individuals applying in Wisconsin whose impairment/ condition are listed on the application, the presumptive disability decision is made by the county or Medicaid eligibility worker. In Wisconsin, supervisors within the Disability Determination

Bureau maintain close communication with hospitals to ensure that patients in urgent need or those presenting a change in medical condition/status can be processed immediately for presumptive disability.

South Carolina Medicaid currently has no presumptive disability process. Based on these findings, the adoption or implementation of a presumptive disability process in South Carolina similar to the one in Wisconsin would expedite the process for patients seeking long term care.

In an attempt to see if such a process in South Carolina could offer any potential savings to the state's Medicaid program, a sample of patients 72 patients seeking long term care or disability decisions was gathered from Palmetto Health Richland and Lexington Medical Center hospitals with the cooperation of the directors of discharge planning. The list included patients admitted between October 1, 2010 and September 30, 2011. These patients were researched through the DHHS Medicaid Eligibility Determination system (MEDS). The MEDS system revealed if an application for Medicaid was filed, the date of approval, denial, and length of time pending a decision. This system also revealed if the application filed was awaiting a disability decision prior to approval or denial. Of the patients providing a positive hit in MEDS, a request for patients' financial statements were made from the hospitals and received. The patients' financial statements verified admission, discharge, and total medical expenditures related to the hospital stay. Once this information was gathered, a report was requested from the DHHS claims division for 13 patients to show actual expenditures paid by Medicaid to the hospitals on their behalf.

The purpose of the data collected was to see how long patients stayed in hospitals awaiting a disability decision in order to be placed in a nursing home. Another purpose of the data was to identify the total cost to the state's Medicaid program for patients admitted over a long period of

time versus the cost associated with an admission to a nursing home for the same period. The current average pay rate for an individual to reside in a nursing home monthly in South Carolina is $5,481.42. Any differences in the payments for an early nursing home admission versus remaining in a hospital setting could be viewed as a potential cost saving to the state's Medicaid.

The data collected showed patients that were admitted to the hospitals for a timeframe ranging from 1 to 13 months. In matching DHHS claims payment report with patient financial statements, the data showed the total expenditures paid by Medicaid for eight patients over an approximate 12 month period of hospitalization was $1,320,021.33. A closer look into the sample showed two patients at Palmetto Health Richland with excess expenses and several months admitted as inpatients. Both patients were seeking long term care services and required disability determinations before a nursing home would accept them for admission. In one case, the patient was admitted for five months while awaiting a disability determination for discharge to a nursing home. A Medicaid claims report reveals that the South Carolina Departments of Health and Human Services paid the medical facility $434,739.74 for this admission. The average cost for a patient to reside in a nursing home for this same period of time is $27,407.10. This is a difference of $407,332.64.

Another case shows a patient admitted for 13 months while awaiting a disability determination and placement to a long term care facility. Our Medicaid claims report shows that the South Carolina Department of Health and Human Services paid the medical facility $660,497.85 for this admission. The average cost for a patient to reside in a nursing home for this same period of time is $65,777.04. This is a difference of $594,720.81.

Although the data collected is a small sample of patients and does not represent any internal medical factors or other barriers that may have contributed to prolonged admissions, there is still a fairly strong indication that South Carolina Medicaid could potentially benefit by implementing a presumptive disability program for its beneficiaries and citizens.

Based on this research and my knowledge of South Carolina Medicaid policies and procedures, I would encourage and recommend the adoption of a presumptive disability process that mirrors the program Wisconsin offers to its citizens. This would expedite our process here in South Carolina for patients seeking a disability determination for long term care. This would also limit the amount of days patients will remain in hospitals, thereby decreasing the cost to the state's Medicaid program. Most importantly, this could potentially improve the overall health of our citizens and in some cases lessen the need for continuous long term care assistance.

In order to successfully implement a presumptive disability process in South Carolina, we would need an addition to our current policy. We would also need to develop a listing of medical conditions and impairments for immediate approval similar to those in Wisconsin, SSA compassionate allowance initiative, and the SSI presumptive disability program. Adding a presumptive disability program will not interfere with current policies and procedures in place that focuses on disability or long term care. In fact, a presumptive disability program will enhance or improve our current processes.

Since South Carolina hospitals are enrolled as providers with DHHS and have a huge stake in the care of patients, I recommend that we partner with these medical institutions to administer this program. This can be done through the Sponsored Medicaid Worker Program. The Sponsored Medicaid Worker Program already exists within DHHS. The program allows medical facilities

such as hospitals, clinics, nursing homes, health centers, medical practices, and some state agencies to contract with DHHS to hire an eligibility worker for their facility. Under the contract agreement, the medical facilities pay half the salary and DHHS pays the match. Workers hired under the sponsored Medicaid worker program are DHHS employees. They are trained and supervised by DHHS, but are often housed or located at sponsors medical facility.

The eligibility workers hired to administer this program will be located within a DHHS regional office. Under this program, eligibility workers will work very closely with the South Carolina Department of Vocational Rehabilitation disability unit, hospital discharge planners, and nursing homes. Their primary function will be to approve patients for Medicaid under the presumptive disability program. A secondary function will include educating hospitals, especially those in rural counties on conditions and impairments qualifying for the presumptive disability program. Educating hospitals and other medical facilities can be accomplished through meetings and the agency provider bulletins. I have included a flow chart which illustrates the functions of the eligibility worker and provides an overview of how this program will work.

Given the interest by hospital discharge planners in expediting this process, I would not anticipate any difficulty or opposition if we approached them about sponsoring two workers to manage this program statewide. We can introduce this idea to the hospitals independently or through the South Carolina Hospital Association. Paying a match of approximately $21,000.00 for each sponsored worker hired is the primary cost associated with administering this program.

The recommendation to implement a presumptive disability program in South Carolina is in line with the agency current strategic plan and mission of improving efficiency by streamlining our eligibility processes and serving as better stewards of taxpayer dollars.

References

- United States. Social Security Administration. *Compassionate Allowances,* . 2011. Web. <www.socialsecurity.gov/compassionateallowances/conditions.htm>.

- United States. Social Security Administration. *Understanding Supplemental Security Income Expedited Payments*. 2011 Edition. Web. <www.socialsecurity.gov >.

- United States. The Department of Health Care Policy and Financing. *Colorado Medicaid Presumptive Eligibility Procedure Manuel*. Web.

- United States. Wisconsin Depart of Health Services. *Wisconsin Medicaid Presumptive Disability*. Web. <dhs.wi.gov/ddb/index.htm>.

- United States. The Kansas Department of Health and Environment. *Kansas Presumptive Disability Medicaid*. Web. <www.kdheks.gov/hcf>.

- United States. Georgia Department of Human Services. *Presumptive Medicaid Coverage for Pregnancy*. Web. <www.ehow.co.uk/facts_6802722_georgia-presumptive-medicaid-coverage....>.
- United States. Kentucky Cabinet for Health and Family Services. *Presumptive Eligibility for Pregnant Women*. Web. <chfs.ky.gov/dms/peservice.htm>.

- United States. Oregon Department of Human Services. *Presumptive Medicaid decision Procedures*. Web. <www.dhs.state.or.us/spd/tools/program/osip/wg4.htm>.

- United States. New Mexico Human Services Department. *Medicaid Presumptive Eligibility*. Web. <www.hsd.state.nm.us/mad/HMedicaid.html>.
- United States. Indiana family and Social services. *Apply for Medicaid (Presumptive Eligibility)*. Web. <member.indianamedicaid.com/apply-for-medicaid.aspx.>.
- United States. *North Carolina department of Health and Human services*. Web. <info.dhhs.state.nc.us/olm/manuals/dma/fcm/man/MA3245-01.htm>.
- United States. Social Security Administration. *Disability Evaluation Under Social Security*. SSA Office of Disability Programs, 2008. Print.

Appendix

Social Security Online

Compassionate Allowances Home

Compassionate Allowances

Complete List of Compassionate Allowances Conditions

Note: Conditions highlighted in Red are effective December 10, 2011.

1. Acute Leukemia
2. Adrenal Cancer - with distant metastases or inoperable, unresectable or recurrent
3. Alexander Disease (ALX) - Neonatal and Infantile
4. Alstrom Syndrome
5. Amegakaryocytic Thrombocytopenia
6. Amyotrophic Lateral Sclerosis (ALS)
7. Anaplastic Adrenal Cancer - with distant metastases or inoperable, unresectable or recurrent
8. Angelman Syndrome
9. Aortic Atresia
10. Astrocytoma - Grade III and IV
11. Ataxia Telangiectasia
12. Batten Disease
13. Bilateral Retinoblastoma
14. Bladder Cancer - with distant metastases or inoperable or unresectable
15. Bone Cancer - with distant metastases or inoperable or unresectable
16. Breast Cancer - with distant metastases or inoperable or unresectable
17. Canavan Disease (CD)
18. Cerebro Oculo Facio Skeletal (COFS) Syndrome
19. Chronic Myelogenous Leukemia (CML) - Blast Phase

20 Corticobasal Degeneration
21 Creutzfeldt-Jakob Disease (CJD) - Adult
22 Cri du Chat Syndrome
23 Degos Disease, Systemic
24 Early-Onset Alzheimer's Disease
25 Edwards Syndrome (Trisomy 18)
26 Eisenmenger Syndrome
27 Endomyocardial Fibrosis
28 Ependymoblastoma (Child Brain Tumor)
29 Esophageal Cancer
30 Farber's Disease (FD) - Infantile
31 Fibrodysplasia Ossificans Progressiva
32 Friedreichs Ataxia (FRDA)
33 Frontotemporal Dementia (FTD), Picks Disease -Type A - Adult
34 Fukuyama Congenital Muscular Dystrophy
35 Gallbladder Cancer
36 Gaucher Disease (GD) - Type 2
37 Glioblastoma Multiforme (Adult Brain Tumor)
38 Glutaric Acidemia Type II (Neonatal)
39 Head and Neck Cancers - with distant metastasis or inoperable or uresectable
40 Heart Transplant Graft Failure
41 Heart Transplant Wait List, 1A/1B
42 Hemophagocytic Lymphohistiocytosis (HLH), Familial Type
43 Hypoplastic Left Heart Syndrome
44 Idiopathic Pulmonary Fibrosis
45 Infantile Neuroaxonal Dystrophy (INAD)
46 Infantile Neuronal Ceroid Lipofuscinoses
47 Inflammatory Breast Cancer (IBC)
48 Junctional Epidermolysis Bullosa, Lethal Type
49 Kidney Cancer - inoperable or unresectable

50 Krabbe Disease (KD) - Infantile

51 Large Intestine Cancer - with distant metastasis or inoperable, unresectable or recurrent

52 Late Infantile Neuronal Ceroid Lipofuscinoses

53 Left Ventricular Assist Device (LVAD) Recipient

54 Leigh's Disease

55 Lesch-Nyhan Syndrome (LNS)

56 Lewy Body Dementia

57 Liver Cancer

58 Lowe Syndrome

59 Malignant Multiple Sclerosis

60 Mantle Cell Lymphoma (MCL)

61 Maple Syrup Urine Disease

62 Merosin Deficient Congenital Muscular Dystrophy

63 Metachromatic Leukodystrophy (MLD) - Late Infantile

64 Mitral Valve Atresia

65 Mixed Dementias

66 MPS I, formerly known as Hurler Syndrome

67 MPS II, formerly known as Hunter Syndrome

68 MPS III, formerly known as Sanfilippo Syndrome

69 Mucosal Malignant Melanoma

70 Multicentric Castleman Disease

71 Multiple System Atrophy

72 Neonatal Adrenoleukodystrophy

73 Niemann-Pick Disease (NPD) - Type A

74 Niemann-Pick Disease-Type C

75 Non-Small Cell Lung Cancer - with metastases to or beyond the hilar nodes or inoperable, unresectable or recurrent

76 Ornithine Transcarbamylase (OTC) Deficiency

77 Osteogenesis Imperfecta (OI) - Type II

78 Ovarian Cancer - with distant metastases or inoperable or unresectable

79 Pancreatic Cancer

80 Paraneoplastic Pemphigus

81 Patau Syndrome (Trisomy 13)

82 Peritoneal Mesothelioma

83 Pleural Mesothelioma

84 Pompe Disease - Infantile

85 Primary Cardiac Amyloidosis

86 Primary Central Nervous System Lymphoma

87 Primary Effusion Lymphoma

88 Primary Progressive Aphasia

89 Progressive Multifocal Leukoencephalopathy

90 Progressive Supranuclear Palsy

91 Pulmonary Atresia

92 Pulmonary Kaposi Sarcoma

93 Rett (RTT) Syndrome

94 Salivary Tumors

95 Sandhoff Disease

96 Single Ventricle

97 Small Cell Cancer (of the Large Intestine, Ovary, Prostate, or Uterus)

98 Small Cell Lung Cancer

99 Small Intestine Cancer - with distant metastases or inoperable, unresectable or recurrent

100 Spinal Muscular Atrophy (SMA) - Types 0 And 1

101 Spinocerebellar Ataxia

102 Stomach Cancer - with distant metastases or inoperable, unresectable or recurrent

103 Subacute Sclerosis Panencephalitis

104 Tay Sachs Disease - Infantile Type

105 Thanatophoric Dysplasia, Type 1

106 The ALS/Parkinsonism Dementia Complex

107 Thyroid Cancer

108 Tricuspid Atresia

109 Ullrich Congenital Muscular Dystrophy

110 Ureter Cancer - with distant metastases or inoperable, unresectable or recurrent

111 Walker Warburg Syndrome

112 Wolman Disease

113 Zellweger Syndrome

A6

WISCONSIN DEPARTMENT OF HEALTH SERVICES
Division of Health Care Access and Accountability
F-10130 (08/10)

DDB

MEDICAID PRESUMPTIVE DISABILITY

INSTRUCTIONS: The Applicant Name and Case Number are to be completed by the county or tribal Income Maintenance worker. Sections I, II and III are to be completed by a medical professional. (A medical professional is a licensed physician, physician's assistant, nurse practitioner, licensed or registered nurse, psychologist, ostepath, podiatrist, optometrist, hospice coordinator, medical records custodian, or social worker.)

This completed form must be returned to the county or tribal agency where the applicant resides. A copy of the completed form will be retained in the applicant's Income Maintenance case file. Applicants who have both an urgent need for services and one of the listed impairments can be determined presumptively disabled for purposes of receiving Medicaid while awaiting a final disability decision by the Disability Determination Bureau. To facilitate the final disability decision, the applicant must still complete the Medicaid Disability Application (F-10112) and Authorization to Disclose Information to Disability Determination Bureau (F-14014) forms.

Persons with an urgent need but whose impairments are not listed can still be determined presumptively disabled. This requires a different process and the decision must be made by the Disability Determination Bureau.

Applicant Name (Last, First, MI)	Case Number
☐ Presumptive disability was determined by the agency	☐ Presumptive disability to be determined by DDB

SECTION I — URGENT NEED FOR MEDICAL SERVICES

I have determined that the above named applicant (check the appropriate box or boxes):

☐ Is a patient in a hospital or other long term care medical institution.

☐ Will be admitted to a hospital or other long term care medical institution if immediate health care treatment is not provided.

☐ Is in need of long-term care and the nursing home or other long term care medical institution will not admit the applicant until Medicaid benefits are in effect.

☐ Is unable to return home from a nursing home or other long term care medical institution unless Medicaid covered in-home services or equipment is available.

☐ Meets none of the above.

SECTION II — IMPAIRMENTS

I have determined that the above named applicant has one or more of the following impairments (check the appropriate box or boxes):

☐ Amputation of a leg at the hip.

☐ Total deafness.

☐ Total blindness.

A7
DDB

- ☐ Bed confinement or immobility without a wheelchair, walker, or crutches due to a condition that is expected to last 12 months or longer.
- ☐ Has had a stroke (cerebral vascular accident) more than three months in the past and continued marked difficulty in walking or using a hand or arm.
- ☐ Cerebral Palsy, Muscular Dystrophy or muscle atrophy and marked difficulty in walking (e.g., use of braces), speaking, or coordination of the hands or arms.
- ☐ Down Syndrome.
- ☐ Severe mental deficiency as claimed by another individual filing on behalf of an applicant who is at least seven years of age. ('Mental deficiency' means mental retardation. This category pertains to individuals whose dependence upon others for meeting personal care needs (e.g., hygiene) and in doing other routine disability activities (e.g., fastening a seat belt) grossly exceeds age appropriate dependence as a result of mental retardation.)
- ☐ Receipt of hospice services because of a terminal condition, including but not limited to terminal cancer, as confirmed by a licensed physician or knowledgeable hospice official (hospice coordinator, staff nurse, social worker, or medical records custodian).
- ☐ Spinal cord injury producing inability to ambulate without the use of a walker or bilateral hand-held devices for more than two weeks, with confirmation of such status from an appropriate medical professional.
- ☐ End stage renal dialysis confirmed by a medical professional.
- ☐ Unable to work or return to normal functioning for at least 12 months or has a condition that will result in death within the next 12 months.
- ☐ A positive diagnosis of HIV with other serious health conditions and will be unable to work or return to normal functioning for at least 12 months or has a condition that will result in death within the next 12 months.
- ☐ Meets none of the above.

SECTION III — MEDICAL PROFESSIONAL INFORMATION			
Printed Name – Medical Professional (Last, First, MI)			
Address - Street	City	State	Zip Code
SIGNATURE – Medical Professional			Date Signed

A8

[redacted] Financials Account Inquiry Processor

Richland Tue Feb 07, 2012 10:12

Account	Name	FC	Typ	Admit	Disch	Balance	Loc
[redacted]	[redacted]	UOS	19	IPR 06/29/10	07/27/11	1894198.70	AR /ACCF

1 Total Charges	2 Total Adj	3 Total Payments	4 Ref?	Exp?	Pat Class
$1,907,385.70	$12,894.29-	$292.71	No	No	

5 Ins Liability	6 Ins Adj	7 Ins Payments	8 Agency
$1,894,198.70	$12,894.29-	$292.71	

9 Pt Liability	10 Patient Adj	11 Pt Payments	12 Last Pt Payment
$0.00	$0.00	$0.00	

13 Wkfl	14 Sch	15 Schd Typ	16 Phone	17 Inv Gu Addr	18 Lst FU Dt	Ty	Sq	Hld
	1	Separate	Y/N/N	No	08/05/11	D	1	No

19 BD Pre-Listed	20 BD Date	21 Agency	22 BD Transfer Amount

23 SSN #	24 Birth Date	25 BillHld	26 DPW/CMS	27 Nts	28 PRE/Adm	29 Accts
[redacted]	[redacted]	No	No/No		Yes /TRB	No

	30 COB	Ins Carrier	#Clm	LCS	SubmitDt	Est Amt Due	Amt Pd	Dsp	Date
	1	MEDICAID	1	1	08/01/11	$1,892,553.7	$0.00	C	01/03/12
$	2	1500 MEDICAID	10	11	08/01/11	$13,187.00	$0.00	P	08/15/11
$	3	1500 BLUE CHOICE	10	21	08/25/11	$4,095.00	$0.00	P	09/13/11

Press NL for Menu, enter code, or '-' for list--

A9

[redacted] Financials Account Inquiry Processor

Richland Tue Feb 07, 2012 10:12

Account	Name	FC	Typ	Admit	Disch	Balance	Loc
[redacted]	[redacted]	19	IPR	08/24/10	01/25/11	0.00	AR /ACCF

1 Total Charges	2 Total Adj	3 Total Payments	4 Ref?	Exp?	Pat Class
$576,786.31	$188,879.62-	$387,906.69	No	No	

5 Ins Liability	6 Ins Adj	7 Ins Payments	8 Agency
$0.00	$188,879.62-	$387,906.69	

9 Pt Liability	10 Patient Adj	11 Pt Payments	12 Last Pt Payment
$0.00	$0.00	$0.00	

13 Wkfl	14 Sch	15 Schd Typ	16 Phone Y/N/N	17 Inv Gu Addr	18 Lst FU Dt	Ty	Sq	Hld
		Separate		No	02/03/11	D	1	No

19 BD Pre-Listed	20 BD Date	21 Agency	22 BD Transfer Amount

23 SSN #	24 Birth Date	25 BillHld	26 DPW/CMS	27 Nts	28 PRE/Adm	29 Accts
[redacted]	[redacted]	No	No/No	Yes	/TRB	Yes

	30 COB	Ins Carrier	#Clm	LCS	SubmitDt	Est Amt Due	Amt Pd	Dsp	Date
$	1	MEDICAID	1	1	01/30/11	$571,601.31	$387,631.14	F	02/07/11
$	2	1500 MEDICAID	4	5	01/30/11	$3,540.00	$180.90	F	02/14/11

Press NL for Menu, enter code, or '-' for list--

A10

[redacted] Financials Account Inquiry Processor

Richland
Account Name Tue Feb 07, 2012 10:11

[redacted] [redacted] FC Typ Admit Disch Balance Loc
19 IPR 05/16/11 06/24/11 0.00 AR /ACCF

1 Total Charges	2 Total Adj	3 Total Payments	4 Ref? Exp? Pat Class	
$150,938.25	$103,822.49-	$47,115.76	No No	
5 Ins Liability	6 Ins Adj	7 Ins Payments	8 Agency	
$0.00	$103,822.49-	$47,115.76		
9 Pt Liability	10 Patient Adj	11 Pt Payments	12 Last Pt Payment	
$0.00	$0.00	$0.00		
13 Wkfl 14 Sch	15 Schd Typ	16 Phone	17 Inv Gu Addr	18 Lst FU Dt Ty Sq Hld
	Separate	Y/N/N	No	No
19 BD Pre-Listed	20 BD Data	21 Agency	22 BD Transfer Amount	
23 SSN # [redacted]	24 Birth Date [redacted]	25 BillHld No	26 DPW/CMS No/No	27 Nts 28 PRE/Adm Yes /TRB 29 Accts Yes

	COB	Ins Carrier	#Clm	LCS	SubmitDt	Est Amt Due	Amt Pd	Dsp	Date
$	1	MEDICAID	1	1	06/29/11	$150,907.25	$47,108.60	F	07/11/11
$	2	1500 MEDICAID	1	2	06/29/11	$31.00	$7.16	F	07/11/11

Press NL for Menu, enter code, or '-' for list--

A11

Payments made by Medicaid

Time Period: 10/1/2010 - 09/30/2011
Provider Type Code: 01
Provider Type: Inpatient Hosp

Person ID	Member First Name	Member Last Name	Provider ID	Provider Name	Net Payment
6780072002	[redacted]	[redacted]	313118	LEXINGTON CO HEALTH SVCS	$47,055.81
8781225213	[redacted]	[redacted]	387175	PALMETTO RICHLAND	$11,751.31
6781205775	[redacted]	[redacted]	387175	PALMETTO RICHLAND	$434,739.74
7283211401	[redacted]	[redacted]	369382	KERSHAW COUNTY MEDICAL CEN	$5,887.88
7283211401	[redacted]	[redacted]	387175	PALMETTO RICHLAND	$3,835.43
7091106001	[redacted]	[redacted]	313118	LEXINGTON CO HEALTH SVCS	$25,121.31
7091106001	[redacted]	[redacted]	387175	PALMETTO RICHLAND	$58,138.16
2020011502	[redacted]	[redacted]	387175	PALMETTO RICHLAND	$660,497.85
1729210101	[redacted]	[redacted]	274472	PROVIDENCE HOSPITAL	$15,214.98
1729210101	[redacted]	[redacted]	387175	PALMETTO RICHLAND	$25,235.31
1729210101	[redacted]	[redacted]	418962	PALMETTO BAPTIST MED CTR C	$7,046.07
8715094701	[redacted]	[redacted]	274472	PROVIDENCE HOSPITAL	$14,822.42
8715094701	[redacted]	[redacted]	387175	PALMETTO RICHLAND	$10,675.06

A12

Payments made by Medicaid

Time Period	10/1/2010 - 09/30/2011				
Provider Type Code	01				
Provider Type	Outpatient Hosp				
Person ID	Member First Name	Member Last Name	Provider ID	Provider Name	Net Payment
6780072002	[redacted]	[redacted]	305153	LEXINGTON CO HEALTH SVCS	$773.98
8781225213	[redacted]	[redacted]	305153	LEXINGTON CO HEALTH SVCS	$1,883.23
6781205775	[redacted]	[redacted]	232488	PALMETTO RICHLAND	$393.04
6781205775	[redacted]	[redacted]	430188	BARNWELL COUNTY HOSPITAL	$410.64
1728629601	[redacted]	[redacted]	232488	PALMETTO RICHLAND	$50.15
1728629601	[redacted]	[redacted]	305153	LEXINGTON CO HEALTH SVCS	$256.20
7283211401	[redacted]	[redacted]	232488	PALMETTO RICHLAND	$59.00
7283211401	[redacted]	[redacted]	328735	KERSHAW COUNTY MEDICAL CEN	$1,549.93
7091106001	[redacted]	[redacted]	197932	FAIRFIELD MEMORIAL HOSPITA	$16.19
1729210101	[redacted]	[redacted]	429453	PROVIDENCE HOSPITAL	$628.17
8715094701	[redacted]	[redacted]	232488	PALMETTO RICHLAND	$743.81

A13

Sponsored Medicaid Worker Program Overview

The Sponsored Medicaid Worker Program was developed in 1987 in response to Medicaid access initiatives being implemented by the SC Department of Health and Human Services (SCDHHS) to meet the medical needs of uninsured and under-insured South Carolina residents. The Sponsored Medicaid Worker Program provides a means for Medicaid providers, medical facilities, state and local government agencies, school districts, health centers, and nursing homes that serve Medicaid beneficiaries to have Medicaid applications taken and eligibility decisions made on-site.

South Carolina Department of
Health & Human Services

Questions regarding the Sponsored Medicaid Worker Program should be directed to:

ATTN: Bureau of Eligibility Processing
1801 Main Street, 3rd Floor
Post Office Box 8206
Columbia, South Carolina 29201-8206

Phone: 803-898-3985
Fax: 803-255-8215
www.scdhhs.gov

South Carolina Department of
Health & Human Services

SPONSORED MEDICAID WORKER PROGRAM (SMWP)

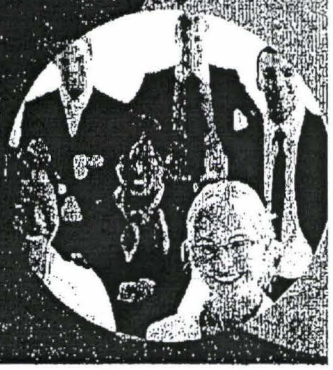
"HELPING MEDICAID WORK FOR YOU"

What is the Sponsored Medicaid Worker Program?

A program that provides a means for Medicaid providers and facilities to have a local SC Department of Health and Human Services Medicaid eligibility worker(s) placed in their facility where patients receive services.

What providers are eligible to participate in the Sponsored Medicaid Worker Program?

Providers must be enrolled in the South Carolina Medicaid Program. Providers include, but are not limited to hospitals, health centers, nursing homes, local government, state agencies, school districts, Managed Care Organizations and physician practices.



Who Benefits from the Sponsored Medicaid Worker Program?

Providers would have the availability of a knowledgeable Medicaid eligibility worker(s) on-site to address Medicaid eligibility questions and/or issues, assist their patients with the Medicaid application process and make Medicaid determinations on-site.

Patients would have the convenience of having a Medicaid eligibility worker on-site to assist with the Medicaid application process and determination without having to go to the local SCDHHS office to apply, residents of all counties would have the convenience of completing the application process outside of their county.

How does the Sponsored Medicaid Worker Program Work?

If a provider decides to sponsor a Medicaid eligibility worker, a Memorandum of Agreement between the SC Department of Health and Human Services and Sponsor would be generated.

The purpose of the Agreement is to ensure citizens of South Carolina have an opportunity to apply for Medicaid benefits at provider locations through the Sponsored Medicaid Worker Program. A local SC Department of Health and Human Services Medicaid eligibility worker(s) would be on-site in the provider's facility five days a week to take and process Medicaid applications. The out-stationed Medicaid eligibility worker(s) would be trained and supervised by the local SC Department of Health and Human Services' county office.

What is the Cost Associated with the Sponsored Medicaid Worker Program?

Sponsors pay 50% of the total cost of the budget for a sponsored Medicaid eligibility worker and all associated costs including equipment, supplies and furniture; which is approximately $21,000 annually. Sponsored Medicaid eligibility worker(s) salaries are based on 12 months of employment and salary cost is prorated if the contract is initiated less than 12 months.

S. C. DEPARTMENT OF HEALTH AND HUMAN SERVICES
SPONSORED WORKERS CONTRACT -REVENUE/COST PROJECTIONS
FISCAL YEAR 2011 - 2012
JULY 1, 2011 THRU JUNE 30, 2012

PROVIDER NAME AND ADDRESS

Entry Level Salary - Band 4, GA 40
Human Services Specialist II
Range - $24,881, $35,457, $46,033

FEIN:
FACILITY:

CONTACT NAME AND TELEPHONE

With Computer & Printer

Telephone
e-mail:
Fax:

I. SALARY COSTS **********FOR IN - HOUSE USE ONLY**********

	# SLOTS	FUNDING LEVEL	TOTAL FUNDS	FEDERAL FUNDS	**MATCH REQUIRED**
	0	Instructor II	0.00	0.00	0.00
	0	Administrative Specialist I	0.00	0.00	0.00
	0	Administrative Specialist II	0.00	0.00	0.00
	0	Administrative Specialist III	0.00	0.00	0.00
	0	Human Services Specialist I	0.00	0.00	0.00
	1	**Human Services Specialist II**	**24,881.00**	**12,440.50**	**12,440.50**
	0	Human Services Specialist III	0.00	0.00	0.00
	0	Human Services Coordinator I	0.00	0.00	0.00
	0	Human Services Coordinator II	0.00	0.00	0.00
		Sub -Total SALARY	24,881.00	12,440.50	12,440.50
	1	TOTAL WORKERS			
		Salary Cost (sub-total X 1.00)	24,881.00	12,440.50	12,440.50
		FRINGES (Salary Cost X .34)	8,459.54	4,229.77	4,229.77
		TOTAL SALARY AND FRINGES	33,340.54	16,670.27	16,670.27
II.	OTHER OPERATING	(# Slots X $1000)	1,000.00	500.00	500.00
		TOTAL OTHER OPERATING	1,000.00	500.00	500.00
III.	DIRECT EQUIPMENT COSTS - Delineate				
	1	Equipment Le Lease	0.00	0.00	0.00
	2	PC and Printer	1250.00	625.00	625.00
	3	P C Maintenance	150.00	75.00	75.00
	4	DSL line	0.00	0.00	0.00
		DIRECT EQUIPMENT- TOTAL	1400.00	700.00	700.00
	CONTRACT SUB-TOTAL		35,740.54	17,870.27	17,870.27
IV	STATE OFFICE MONITORING&SUPPORT 20%		7,148.12	3,574.06	3,574.06
V.	PRIOR YEAR - ADJUSTMENT		0.00	0.00	0.00
VI.	**CONTRACT TOTAL**		**42,888.66**	**21,444.33**	**21,444.33**

NOTES:
Other Operating Costs Include: Office Supplies, Travel, Telephone, Postage, etc.
State Office Monitoring Costs Include: Training, Reporting, Monitoring and Safeguard of information etc

Presumptive Disability Process Flow Chart